

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027682

FILED VS AUG 10 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2047 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		Length of stay in 1b 1 hr.	c. CITY OR TOWN Wellston Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Ostp. Hospt.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1601 Vassier Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Ama Middle D. Last Hanners	4. DATE OF DEATH Month 7 Day 30 Year 1959
--	---

5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-3-1907	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
----------------------	-------------------------------	---	----------------------------------	----------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	--	---

13a. FATHER'S NAME Elive W. Allen	13b. MOTHER'S MAIDEN NAME Minnie C Smith	14. NAME OF HUSBAND OR WIFE Rayford Hanners
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Rayford Hanners 1601 Vassier
---	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Acute medullary fracture		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) 2. Cerebral hemorrhage	12 hr
	DUE TO (c) 3. Arterio-sclerosis	10 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
--	---	--

20c. TIME OF INJURY Hour 12 a.m. p.m.	Month, Day, Year
---	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT-WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	--	---

21. I attended the deceased from **January 1950** to **July 1959** and last saw her/him alive on **July 30, 1959**
Death occurred at **12 noon** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title)	22b. ADDRESS 6201 Lottin	22c. DATE SIGNED 7-31-59
---	---------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-3-1959	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
---	---------------------------	---	--

24. FUNERAL DIRECTOR Jos. W. Clark F.H. 1125 Hodiamont	ADDRESS	25. DATE RECD. BY LOCAL REG. 7-31-59	26. REGISTRAR'S SIGNATURE [Signature]
---	---------	---	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harvey Kadle

Licensed Embalmer No. 4596

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.